Anglia Care Homes Limited

Bellevue Residential Care home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 2 March 2017 and was unannounced. Bellevue Residential Care Home provides care and accommodation for up to ten older people. The service supports people living with a diagnosis of dementia and or mental health needs. There were nine people living at the service on the day of our inspection.

The service has a registered manager, who was also the provider. The manager was also registered to manage another care home for older people in Clacton. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not always sufficient staff available. This was a small service providing care for people with complex needs. Staff responsibilities as well as providing personal care support also included cooking, cleaning, providing activities. We identified shortfalls in these areas.

Checks were undertaken on newly appointed staff before they started work in the service but the recruitment process in place would benefit from being further strengthened.

Medicines were not always given as prescribed and there was a lack of clarity about who should be given what medicines and when.

The risks surrounding the care of people diagnosed with diabetes, at risk of acquiring a pressure ulcer and moving and handling were not always managed in a way that minimised the risks to people. Checks were undertaken on the environment and equipment to check that it was safe; however we found a number of concerns which had not been identified or addressed. Following the inspection we asked the fire officer to visit the service to advise the provider as to steps they should take to mitigate the risks to people's safety. The environment was not consistently clean and hygienic.

Training for staff was provided but it was not effective. The majority of training was provided by manager. We identified concerns about staff understanding of current good practice. For example, staff did not demonstrate knowledge of safe care and best practice in areas such moving and handing and infection control. Mental Capacity and staff knowledge of their responsibilities was not clearly understood and ensuring consent was not embedded into practice.

The food looked appetising and people enjoyed the meals but some individuals would have benefited from more support. People had access to health care support and we saw that the staff referred people appropriately.

Individual staff were kind and caring. However support focused on the provision of tasks and care was not

always person centred or individualised. There were some communication issues as some staff skills in understanding and communicating in the English language were limited. Interactions were warm and respectful but staff did not fully understand issues such as privacy and confidentiality. The environment did not fully promote peoples independence.

Efforts had been made to develop care planning and ascertain people's wishes and preferences however staff were not familiar with the plans. This meant that care was not always delivered in a consistent way or in a way that reflected best practice. Best practice for example in supporting people living with dementia was not consistently being delivered to promote peoples mental stimulation and meaningful activity.

The manager and the deputy manager worked across both of the provider's services and covered care shifts as well as providing leadership to the staff team. Staff told us that they were approachable but we had concerns about their accessibility and their ability to drive improvements at this and the other provider service. There were quality assurance systems in place but these had not identified some of the issues we identified at this inspection and further work is needed to ensure that they are effective.

During this inspection we identified breaches of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There was not always sufficient staff available to meet people's needs

We found that risks to people were not always identified assessed and minimised.

Medicines were not always managed safely

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not always have the skills and knowledge to meet people's needs.

Staff did not have a good understanding of consent or capacity and this meant that people may not be fully consulted and their wishes ascertained or met.

People were supported to access health services.

Meals looked appetising but further efforts were needed to promote peoples nutritional intake.

Is the service caring?

Requires Improvement

The service was not always caring.

Individual staff were caring but the time they spent with people was limited and care was not always person centred.

The environment did not always promote peoples independence or privacy

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Care plans had been revised but were not always implemented by staff.

People had limited access to activities to promote their mental stimulation and provide comfort.

Complaints procedures were in place and displayed.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Management was not always visible.

Audits were being undertaken but they did not always identify some of the areas that we found during our inspection.

Bellevue Residential Care home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 2 March 2017 and it was unannounced. The inspection team consisted of two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information that we held about the service and made contact with the local quality monitoring team who had visited the service.

There were nine people living in the service and we spoke with six of the people living there, two visiting health professionals and four staff. Because not everyone at the service could tell us about their experience be undertook a SOFI which is an observational assessment tool which looks at peoples wellbeing. We looked at three staff records; peoples care records and records relating to how the safety and quality of the service was being monitored. We observed care practice and medication administration. Following the inspection we gave feedback to the senior member of staff on duty as the manager was on holiday. We subsequently spoke with the manager/provider by telephone about the issues we had found.

Requires Improvement

Is the service safe?

Our findings

There was not always sufficient staff available to meet people's needs. There were two care staff on duty for the majority of the working day. An additional member of staff attended the service for a two hour period in the middle of the day. Care staff provided personal care but also undertook cleaning, housekeeping duties, cooking, medication and activities to promote social stimulation. We found shortfalls in these areas. We looked at the provider's dependency scoring system and saw that six people had been identified as having high needs. One person was medium and two were low. This corresponded with our observations, as there were a number of people who were cared for in bed, who required two staff to support them and had been identified as requiring palliative care. Some of these individuals were unable to use a call bell and therefore needed regular checks. We saw that staff were busy and there were periods when the two staff on duty were involved supporting one person leaving the remainder of the service without staff to respond to people's needs. For example we saw that one person had been served their meal but clearly needed more support. We spoke to a member of staff as we observed that they were unable to eat what they were served independently and their plate of food had slipped onto their knee. We observed that another person was in bed and was wet and uncomfortable and we asked staff to assist them. Throughout the day we observed that staff were busy undertaking tasks such as preparing food and did not have time to sit with people. There was one waking night member of staff and a member of staff who slept in and on call. The provider told us that the member of staff who slept in got up during the night to help reposition individuals.

The shortfalls in staffing are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked the systems in place to support people with their medicines and found that they were not always managed safely. We observed that staff were crushing peoples medicines and when we spoke to staff we found that there was a lack of clarify about whose medication was being crushed and the procedure for doing so. There was no evidence that the individuals GP or the pharmacist had been consulted about whether this was safe practice.

We saw that where people had been prescribed medicines to be administered on an 'as and when required' basis known as (PRN) there was not always up to date care plans with PRN protocols in place which would describe what these medicines were prescribed for, what symptoms for staff to look out for. There was no pain assessment tool in use to support people who may not be able to articulate their pain.

Creams and lotions had been prescribed for some individuals and we found that they were not always maintaining records to evidence that these had been administered as prescribed.

Medicines were stored securely and there were systems in place to record temperatures and ensure that they were being stored at the recommended levels. Peoples support plans stated the levels of support people wanted with their medicines, for example, 'I would like to have my medication after I have my breakfast meal….staff to put it in my hand and take it with a glass of water or orange juice.' However staff were not always following this and we observed an individual being given their medication with their meal

without a drink.

We found that risks to people were not always identified, assessed and minimised. Assessments of peoples moving and handling needs were undertaken but the documentation did not always record the type or size of equipment which was suitable for individuals such as the size of sling. We observed staff assisting an individual to move from the bed to their chair, using a handling belt. The person was not weight bearing and therefore not suitable for the equipment in use. This posed a risk of harm to both the individual and the staff assisting.

We found that the service was supporting an individual who had diagnoses of diabetes and were involved in taking the individual's bloods. However the management plan was not sufficiently clear and this meant that people may not receive the care that they needed. For example it did not set out what actions staff should take when they received a very high or low reading as well as information regarding the signs of high and low sugars and what they should look out for. We did note that staff had sought advice from the GP where they did have a concern but where guidance had been given it was not being consistently followed. This lack of clarity meant that the individual was at risk of unsafe care

Waterlow risk assessments were undertaken to identify those at risk of pressure damage. Where risks were identified, specialist mattresses were in place to reduce the likelihood of injury. However we found that there was no guidance or information in the care plan concerning the correct setting of the mattress for people's weight. It is vital to ensure the mattress is set correctly to obtain the most effective pressure relief.

Information on accidents and incidents was collated and where individuals had a number of falls we saw that referrals had been made to the falls service. Where individuals sustained bruising, body maps were completed but there was no analysis to ascertain the reason or check whether there was correlation between this and moving and handling practice.

The shortfalls we found in safety demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Environmental risks were inconsistently managed. We saw that checks were being undertaken on a range of equipment such as, water temperatures and hoists to ensure that they were safe. We could not see that checks were being undertaken on slings as required and we found one sling where the label was very worn and we could identify the size from the label. Checks on fire equipment were undertaken to make sure they could be used in an emergency. However their use of a door wedge would impact significantly on the fire safety systems and prevent them from working effectively. Following our inspection we spoke with the fire officer about our concerns and they agreed to undertake a visit to the premises.

We also identified a number of environmental risks which had not been identified by the provider. We found free standing wardrobes in people's rooms which had not been secured to the wall. A number had cases on top and we expressed concerns that people could inadvertently pull the wardrobes over. The door to the cupboard which was used to store chemicals and other products was unlocked posing a risk. There were no thermometer in place for staff to test water temperatures and staff told us that they were using the food temperature probe for testing which posed some environmental health risks. The senior in charge told us that they would request that the provider purchase additional thermometers and arrange for a plumber to visit to address some of the other issues we identified such as a blocked sink and a cold radiator in the bathroom.

People were not always being provided with a clean and hygienic environment and the risks associated

with infection were not well managed. We found some areas were in need of cleaning including floors and the bathrooms. In one of the toilets we found a single use catheter bag, complete with offensive smelling urine placed in the 'swing bin' with the knotted drainage tube hanging outside the bag. Staff knotting the end of the tube, demonstrated that they were aware it still had the urine in and was at risk of spilling out. The senior carer when asked, confirmed that the urine should have been removed. The room also had a mop soaking in dirty water. Dirty and discoloured mops were found propped, mop head down, in pools of water in shower trays, posing a risk of infection. Clean towels were being stored in proximity to the toilet on a commode seat.

This demonstrated a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We reviewed the recruitment records for the two recently employed staff. We found that identification checks had been undertaken along with disclosure and barring checks (DBS). References had been requested from previous employer . On the day of the inspection we saw that one of the people had only one reference in place, but we subsequently received assurances from the provider that there were two. However we could not see that there was a record of interview and were therefore not satisfied that the provider had effective recruitment procedures to ensure that the staff they appointed had the skills necessary for the work they were employed to perform.

Staff told us that they had undertaken training on safeguarding and knew what abuse was. All of the staff we spoke with said they would report bad practice to the manager if they witnessed it and would complete a body map. However, they were unable to demonstrate any knowledge or awareness of local safeguarding protocols and how to refer matters of concern to the local safeguarding authority. We saw records which showed that staff were completing body maps and noting bruising but we could not see that there had been any investigation to determine the cause.

Requires Improvement

Is the service effective?

Our findings

Staff training was not effective. We spoke to the staff about the training they received for their role. Staff told us that the majority of the training was provided by the manager. Some of the staff we spoke to had not undertaken training on key areas such as dementia or the management of diabetes. Other staff told us that they had completed training on dementia but we established that the session consisted of only a two hour session which did not provide them with the guidance they needed. We were shown a file containing certificates which had been completed by the manager to evidence that staff had completed training in areas such as nutrition, medication, infection control and moving and handling. We were told that new staff worked on a supernumerary basis as part of the their induction before working independently and were shown a checklist which had been signed to evidence that one of the new staff members had completed training on areas such as fire to ensure that they would know what to do in the event of the a fire.

In the provider information return (PIR) which the manager completed prior to our inspection, they told us that they regularly checked staff competency. However across the service we could not see that the training undertaken by staff was being effectively implemented, as we observed inconsistent practice during the inspection. For example we observed staff did not always demonstrate knowledge of best practice in the safe moving and handling of people, medication and infection control. Staff we spoke to were not clear how often they should be changing a catheter bag and we observed a member of staff offering an individual who was a diabetic, biscuits high in fat and sugar. There were shortfalls in the support offered to people living in the service who had a diagnosis of dementia and the care did not always reflect best practice. This meant that the training was not effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager told us in the PIR that they had provided staff with training on the MCA and staff confirmed this; however it was clear from our discussions with them and our review of the documentation that they lacked adequate understanding of their roles and responsibilities with regards to the Mental Capacity Act 2005 and DoLS. For example we saw that one person had a DNA/CPR in place which said that they should not be resuscitated in the event of an emergency. The form said that care staff had been consulted about this but this information conflicted with their wishes as recorded in their care plan, which stated that they would like to be resuscitated and go to hospital if unwell. We asked the deputy manager to follow this up and ensure that this individual's wish was clarified, appropriately recorded and met.

Gaining consent from people was not embedded as part of practice. We did observe some good practice such as a member of staff speaking to an individual before getting them a tissue however we also observed another member of staff wiping an individual's nose without speaking to the person or getting their permission. The individuals care plan stated, 'Give me a tissue and I will wipe my nose'

The meal served during the day of the inspection looked appetising and people enjoyed it. However improvements are needed to the levels of support offered. We observed that one person had a plate guard in place and this enabled them to eat independently. However there was no visible finger food which may have been helpful for some individuals. Some people's meals were pureed and we observed a member of staff assisting one person to eat and this was undertaken in an appropriately paced way however staff used a large spoon which meant that the individual was given a large amount in their mouth at the time. People were offered regular drinks but there were no nutritional snacks visible and we observed people being offered biscuits. One person for example had been identified as being at risk of malnourishment. We did not see that they were offered any extra snacks although the persons care records stated that they liked items such as cake and chocolate.

People were supported to access health care but the care planning documentation did not provide a consistent plan of care to guide staff in providing consistency of care. However there were records on people's files to evidence that they had seen the chiropodist and optician and we saw that referrals had been made to the GP and other health professionals such as community nurses

Requires Improvement

Is the service caring?

Our findings

Individual staff were caring and we observed kind and caring interactions with individuals living in the service. However the shortfalls in the numbers of staff meant that staff were busy and that they did not have time to sit down with people. A lot of the care was task based and focused on helping people to move, use the toilet and have a drink. Some people spent the majority of the time in their room and we were told that although they could not use the call bell, staff undertook regular checks on them. We saw that some checks were undertaken, but we asked staff to support some people on a number of occasions during the day of our inspection as they told us that they were uncomfortable or we saw that they needed assistance.

Staff spoke to people but were busy with task related activities and did not always have time to wait for their response before proceeding. There were also some communication issues as some staff skills in understanding and speaking the English language was limited and this meant that they were not able to communicate in a meaningful way, particularly with people with dementia. For example we observed staff assisting people without speaking or explaining what was happening. Staff did not always act on the wishes of people as outlined in the care plan for example we observed a person not being given the support they had requested when they were being given their medicines.

People looked clean and were wearing clothes which looked comfortable and fitted them. The men were shaved. Bedrooms were personalised according to people's interests and there were pictures of importance to individuals visible. We observed some of the people who lived at the service coming and going between their bedroom and the communal areas throughout the day which demonstrated to us that they were able to decide where they wished to spend their time.

The environment did not always promote the independence of people using the service. For example some doors had people's names on them but not all. Toilets were not always clearly labelled which did not enable people with dementia to clearly orientate themselves round the service

Staff were respectful in terms of interactions but they did not have a good understanding of privacy and confidentiality. For example we observed that staff used the dining room as an office and general meeting room area but this was also used by people living in the service. Handovers and meetings with visiting professionals were undertaken in this area. The bathroom on the first floor did not have a window covering which meant that people's privacy may not be respected.

Resident meetings were held and we were shown minutes of meetings with people who lived in the service and relatives.

Requires Improvement

Is the service responsive?

Our findings

The manager told us that they had implemented a new care planning system and we saw that each individual had a clear plan which included details of their needs, preferences and how they wished to be supported. The plans were informative however; staff were not familiar with the contents which meant that care was not person centred or responsive to people's needs. For example we found that staff did not use specific continence pads which had been prescribed and allocated for specific individuals and we observed a member of staff coming into another individuals' room and removing two continence pads to use for another resident. The use of two pads simultaneously is not good practice. Continence aids are individually assessed and belong to the individual and are their property and to be respected as so. Also failure to use the assessed continence item is detrimental to individual's skin and could lead to leakage around the continence pad.

We had concerns about the support provided to people with dementia and how staff promoted their overall wellbeing. We observed that one individual remained sitting at the table throughout the eight hours of our inspection. We saw in the individuals care plan that , ' I like doing things myself like playing my mini blocks, touch therapy, DIY things, colouring, pen with a paper' 'staff to provide me those activities what I like' However we did not observe the use of these items being provided or these activities instigated by staff during the day . Where people were not supported to access mental stimulation, this put them at risk of social isolation.

Prior to the inspection we had received concerns about the level of stimulation provided to one individual. We saw that they had items in place which would have provided some comfort and stimulation such as a hand muffler but these were not in use and out of reach.

People had limited opportunities to follow their interests. During our visit to the service we observed some, one to one interaction with people and we saw that a member of staff supported two people to play a game of dominoes and threw a ball towards another person for them to catch.
However there were a number of people in their rooms, isolated in bed with little engagement. One person had a book with pictures but would have benefited from some sensory input, Two other people were in bed and there was nothing for them to look at or touch. We saw that in one person's care plan they liked music but there was none playing for them to listen to.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider told us that they had not received any complaints but we saw that there was a policy on display and a form for people to complete if they wished to raise an issue.

Requires Improvement

Is the service well-led?

Our findings

The provider was the registered manager but they also managed another nearby residential home for older people, which they also owned. They were supported by a deputy manager who worked across both services. At the time of our inspection the manager had been away from the service for three weeks. The deputy manager had been working across both services and covering care shifts, as they were not fully staffed. We observed that they were committed and caring but were struggling to cover care shifts and provide effective leadership to both services in the manager's absence. We saw that the staffing rota was only prepared a short period in advance which meant that staff were not able to plan effectively and we were not assured that there would be sufficient staff to cover in an emergency.

People and staff told us that while the manager visited the service on an occasional basis they were not always visible. The manager assured us that they visited the service four or five times each week. Staff told us that they felt supported in their role and had regular access to discuss any concerns and could seek advice by telephone. Staff were complimentary about the deputy manager and told us that they were supportive and caring. We saw records to evidence that staff received supervisions and appraisals were undertaken. We saw that staff meetings were held on an ongoing basis.

Bellevue is a small care home and only supports ten people and was described as homely and "Like a family" by staff. However staff practice was largely task based and there was scope to improve the quality of care people experienced. Best practice for example in dementia care was not consistently being delivered to promote peoples mental stimulation and activity.

We saw that the local authority quality team had been providing additional support to this provider helping them to develop systems to monitor and raise the quality and safety of the care. There were some quality assurance systems in place and some of these were informative. For example we saw that there were checks on whether people had baths, checks on people's weights and we saw they collated information on accidents and made referrals to the falls service. However there needs to be more robust auditing of practice and competency in order to drive improvement at the service. For example in their PIR which the manager completed before the inspection, they stated 'Our medication audits show the staff manage medicines, consistently and safely.' This was not what we found. Similarly on cleanliness they stated, 'We have audits of cleanliness and infection control and the compliance is good. We manage the control of infection well.' Again this contrasted with our findings and we concluded that the quality monitoring systems were not working effectively.

Registered providers are required to notify the Care Quality Commission (CQC) about events which may affect people who use the service. This helps CQC to undertake its responsibilities with regard to safely of people who use service. The deputy manager told us that they had completed notifications but we could not see that these had always been received. We have asked the service to resend the recent notifications which they had made to ensure that our records are up to date.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Staff were not familiar with the contents of the care plans which meant that care was not always delivered in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always well managed and this meant that people were at risk

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises was not consistently clean

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff available to meet peoples needs